



Washington State Department of
Health
Health Professions Quality Assurance
Respiratory Care Practitioner Program
P.O. Box 47869
Olympia, WA 98504-7869

Verification of Licensure / Certification / Registration

Part 1—To be completed by applicant

Complete Part 1. Submit form(s) to all State respiratory care programs where you have ever been licensed, certified, or registered. (That state(s) will then complete part two and submit to our office.)

Name _____

I was registered by the _____ Board/Committee of the respiratory care

Program under the name _____.

My original certificate number is _____

My address is _____

SIGNATURE OF APPLICANT

Part 2

To be completed by the state respiratory care program and returned to: Washington State Department of Health, Respiratory Care Practitioner Program, P.O. Box 47869, Olympia, WA 98504-7869. (Physical Address: 310 Israel Road SE, Tumwater, WA 98501-7869)

License issued on _____ License Number _____

Applicant Licensed by: Exam Endorsement Waive

Status of License:

- Current (Expiration Date) _____
 Not Current (Provide Expiration Date) _____

If not current, please explain: _____

Has license ever been encumbered in any way? (Revoked, suspended, surrendered, restricted, placed on probationary status or under investigation.) _____

(SEAL)

SIGNATURE

NAME AND TITLE

STATE